FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032862

Facility Name: DANVILLE CARE CENTER

Address: 1701 N. BOWMAN AVE (Number) DANVILLE (City) 61832 (Zip Code)

County: VERMILLION

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-3532095

Date of Initial License for Current Owners: 10/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) BRADLEY ALTER

(Title) SECRETARY

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	30,012	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,229	3,229	8
9	SNF/PED					9
10	ICF	35,655	4,217	1,413	41,285	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,655	4,217	4,642	44,514	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.81%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,229

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	215,302	13,633	9,004	237,939		237,939		237,939			1
2	Food Purchase		196,256		196,256		196,256	(744)	195,512			2
3	Housekeeping	184,848	36,306		221,154		221,154	137	221,291			3
4	Laundry	82,855	35,701	674	119,230		119,230		119,230			4
5	Heat and Other Utilities			146,982	146,982		146,982		146,982			5
6	Maintenance	70,608	42,702	35,876	149,186		149,186	77	149,263			6
7	Other (specify):*			8,696	8,696		8,696		8,696			7
8	**TOTAL General Services**	553,613	324,598	201,232	1,079,443		1,079,443	(530)	1,078,913			8
	B. Health Care and Programs											
9	Medical Director			7,548	7,548		7,548		7,548			9
10	Nursing and Medical Records	1,435,910	100,271	139,314	1,675,495		1,675,495	23,300	1,698,795			10
10a	Therapy	155,832	1,688	2,409	159,929		159,929		159,929			10a
11	Activities	67,806	2,233	2,472	72,511		72,511		72,511			11
12	Social Services	68,120		3,466	71,586		71,586		71,586			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,727,668	104,192	155,209	1,987,069		1,987,069	23,300	2,010,369			16
	C. General Administration											
17	Administrative	102,126		61,440	163,566		163,566	2,205	165,771			17
18	Directors Fees											18
19	Professional Services			114,249	114,249		114,249	(645)	113,604			19
20	Dues, Fees, Subscriptions & Promotions			13,996	13,996		13,996	(4,067)	9,929			20
21	Clerical & General Office Expenses	132,961	29,482	213,274	375,717		375,717	(38,525)	337,192			21
22	Employee Benefits & Payroll Taxes			507,848	507,848		507,848	30,645	538,493			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,341	7,341		7,341	11,529	18,870			24
25	Other Admin. Staff Transportation			11,335	11,335		11,335	14,702	26,037			25
26	Insurance-Prop.Liab.Malpractice			123,055	123,055		123,055	4,225	127,280			26
27	Other (specify):* marketing	30,904			30,904		30,904		30,904			27
28	**TOTAL General Administration**	265,991	29,482	1,052,538	1,348,011		1,348,011	20,069	1,368,080			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,547,272	458,272	1,408,979	4,414,523		4,414,523	42,839	4,457,362			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DANVILLE CARE CENTER **#0032862** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,004	
	REPAIRS & MAINTENANCE		0	
			0	9,004
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		674	
			0	674
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,547	
	ELECTRICITY		81,723	
	WATER		38,530	
	CABLE TV - LOBBY		182	
			0	146,982
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,007	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,948	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,950	
	FIRE SERVICE		2,971	
			0	
			0	
			0	35,876
7	**OTHER**			
	SCAVENGER		8,696	
	SECURITY SERVICE		0	8,696
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,548	7,548

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	125,044	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		12,547	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,323	
	PHARMACY CONSULTANT	XVIII B 39-2	400	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	139,314
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		880	
	SPEECH THERAPY SERVICES		300	
	OCCUPATIONAL THERAPY SERVICES		1,073	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	156	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,409
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,472	
			0	2,472
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,466	
			0	3,466
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DANVILLE CARE CENTER **#0032862** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	61,440	61,440
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,997	
	ADMINISTRATIVE CONSULTANTS	XIX C	44,280	
	PROFESSIONAL FEES	XIX C	60,972	
			0	114,249
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,119	
	EMPLOYEE WANT ADS	XIX F	4,462	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	250	
	LICENSES & PERMITS	XIX F	5,165	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	13,996
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		155	
	OUTSIDE CLERICAL SERVICES		186,474	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,762	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		115	
	TELEPHONE		18,925	
	MESSENGER SERVICE		2,843	
			0	213,274

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	189,479	
	UNEMPLOYMENT COMPENSATION	XIX D	95,923	
	WORKERS COMPENSATION INSURANCI	XIX D	113,824	
	HOSPITALIZATION INSURANCE	XIX D	104,824	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,736	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,062	
	CHICAGO HEAD TAX	XIX D	0	507,848
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	5,313	
	TRAVEL	XIX G	2,028	
			0	
			0	7,341
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,335	11,335
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		123,055	123,055
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,408,979

DANVILLE CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	196,256	PATIENT MEALS	133542
LESS SALES TAX	(744)	ADD EMPLOYEE MEALS	0
NET FOOD	195,512	TOTAL MEALS/YEAR	133542
TOTAL PATIENT CENSUS	44,514	NET FOOD	195512
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	133542
TOTAL PATIENT MEALS	133542	COST PER MEAL	1.46
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number DANVILLE CARE CENTER #0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			75,943	75,943		75,943	192,479	268,422			30
31	Amortization of Pre-Op. & Org.							26,667	26,667			31
32	Interest			22,092	22,092		22,092	471,616	493,708			32
33	Real Estate Taxes			60,097	60,097		60,097		60,097			33
34	Rent-Facility & Grounds			530,632	530,632		530,632	(521,829)	8,803			34
35	Rent-Equipment & Vehicles			4,722	4,722		4,722	657	5,379			35
36	Other (specify):*											36
37	**TOTAL Ownership**			693,486	693,486		693,486	169,590	863,076			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		133,493	10,390	143,883		143,883		143,883			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		133,493	120,190	253,683		253,683		253,683			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,547,272	591,765	2,222,655	5,361,692		5,361,692	212,429	5,574,121			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,702	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(744)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,762)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,119)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 77		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	212,352		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 212,352		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 212,429		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DANVILLE CARE CENTER

ID# 0032862

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(744)	0	0	0	0	0	0	0	0	0	0	(744)	2
3	Housekeeping	0	0	137	0	0	0	0	0	0	0	0	137	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	77	0	0	0	0	0	0	0	0	77	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(744)	0	214	0	0	0	0	0	0	0	0	(530)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	23,300	0	0	0	0	0	0	0	0	23,300	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	23,300	0	0	0	0	0	0	0	0	23,300	16
	C. General Administration													
17	Administrative	0	(61,440)	63,645	0	0	0	0	0	0	0	0	2,205	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(4,428)	3,783	0	0	0	0	0	0	0	0	(645)	19
20	Fees, Subscriptions & Promotions	(4,119)	0	52	0	0	0	0	0	0	0	0	(4,067)	20
21	Clerical & General Office Expenses	(4,762)	(179,901)	146,138	0	0	0	0	0	0	0	0	(38,525)	21
22	Employee Benefits & Payroll Taxes	0	0	30,645	0	0	0	0	0	0	0	0	30,645	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	11,529	0	0	0	0	0	0	0	0	11,529	24
25	Other Admin. Staff Transportation	0	0	14,702	0	0	0	0	0	0	0	0	14,702	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,225	0	0	0	0	0	0	0	0	4,225	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,881)	(245,769)	274,719	0	0	0	0	0	0	0	0	20,069	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,625)	(245,769)	298,233	0	0	0	0	0	0	0	0	42,839	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,702	179,449	3,328	0	0	0	0	0	0	0	0	192,479	30
31	Amortization of Pre-Op. & Org.	0	26,667	0	0	0	0	0	0	0	0	0	26,667	31
32	Interest	0	471,616	0	0	0	0	0	0	0	0	0	471,616	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(530,632)	8,803	0	0	0	0	0	0	0	0	(521,829)	34
35	Rent-Equipment & Vehicles	0	0	657	0	0	0	0	0	0	0	0	657	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,702	147,100	12,788	0	0	0	0	0	0	0	0	169,590	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	77	(98,669)	311,021	0	0	0	0	0	0	0	0	212,429	45

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SEE ATTACHED SCHEDULE		CERTIFIED HEALTI	SKOKIE	BKKPG/MGMT
RITA L. GELLER	38.04			MGMT		
JOSEPH C. CHOW	39.13					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 61,440	CERTIFIED HEALTH MGMT		$	$ (61,440)	1
2	V	21	BOOKKEEPING	186,474				(186,474)	2
3	V	19	ADMIN CONSULTING FEES	4,428				(4,428)	3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	530,632	DANVILLE CARE CENTER LLC			(530,632)	7
8	V	30	DEPRECIATION		" " "		179,449	179,449	8
9	V	31	AMORTIZATION		" " "		26,667	26,667	9
10	V	32	INTEREST		" " "		471,616	471,616	10
11	V	21	OFFICE EXP		" " "		6,573	6,573	11
12	V								12
13	V								13
14	Total			$ 782,974			$ 684,305	$ * (98,669)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 137	$ 137	15
16	V	5	ELECTRIC & GAS		" " "		0		16
17	V	6	MAINTENANCE		" " "		77	77	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		23,300	23,300	18
19	V	17	ADMIN SALARIES		" " "		63,645	63,645	19
20	V	19	PROFESSIONAL FEES		" " "		3,783	3,783	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		52	52	21
22	V	21	OFFICE EXP.		" " "		146,138	146,138	22
23	V	22	EMPLOYEE BENEFITS		" " "		30,645	30,645	23
24	V	24	TRAVEL/SEMINAR		" " "		11,529	11,529	24
25	V	25	TRANSPORTATION		" " "		14,702	14,702	25
26	V	26	INSURANCE		" " "		4,225	4,225	26
27	V	30	DEPRECIATION		" " "		3,328	3,328	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		8,803	8,803	29
30	V	35	EQUIPMENT RENTAL		" " "		657	657	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 311,021	$ * 311,021	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 52,696	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,696		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	244,189	8	$ 750	$	44,514	$ 137	1
2	5	ELECTRIC & GAS	" " "	244,189	8	0		44,514	0	2
3	6	MAINTENANCE	" " "	244,189	8	420		44,514	77	3
4	10	NURSING/MEDICAL RECORDS	" " "	244,189	8	127,817	127,817	44,514	23,300	4
5	17	ADMIN SALARIES	" " "	244,189	8	349,136	349,136	44,514	63,645	5
6	19	PROFESSIONAL FEES	" " "	244,189	8	20,751		44,514	3,783	6
7	20	FEE, SUBSCRIPTIONS	" " "	244,189	8	285		44,514	52	7
8	21	OFFICE EXP.	" " "	244,189	8	801,665	683,000	44,514	146,138	8
9	22	EMPLOYEE BENEFITS	" " "	244,189	8	168,109		44,514	30,645	9
10	24	TRAVEL/SEMINAR	" " "	244,189	8	63,242		44,514	11,529	10
11	25	TRANSPORTATION	" " "	244,189	8	80,653		44,514	14,702	11
12	26	INSURANCE	" " "	244,189	8	23,179		44,514	4,225	12
13	30	DEPRECIATION	" " "	244,189	8	18,257		44,514	3,328	13
14	32	INTEREST	" " "	244,189	8	0		44,514	0	14
15	34	OFFICE RENT	" " "	244,189	8	48,291		44,514	8,803	15
16	35	EQUIPMENT RENTAL	" " "	244,189	8	3,606		44,514	657	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,706,161	$ 1,159,953		$ 311,021	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DANVILLE CARE CENTER LLC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 179,449	$	1	$ 179,449	1
2	31	AMORTIZATION		1	1	26,667		1	26,667	2
3	32	INTEREST		1	1	471,616		1	471,616	3
4	21	OFFICE EXP		1	1	6,573		1	6,573	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 684,305	$		$ 684,305	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BARRY KIRSCHENBAUM	X		MORTGAGE	$52,439.00	1/1/98	$ 6,300,000	$ 5,709,539	1/1/23	8.9000	$ 471,616	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				505,809		PRIME+	16,501	6
7	BANK FINANCIAL		X	WORKING CAPITAL				100,000		PRIME+	1,724	7
8	INSURANCE FINANCING		X	INS FINANCING							3,867	8
9	TOTAL Facility Related				$52,439.00		$ 6,300,000	$ 6,315,348			$ 493,708	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,300,000	$ 6,315,348			$ 493,708	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 62,083	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 60,485	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,598)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,695	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 60,097	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	51,543	8
	2000	57,848	9
	2001	59,372	10
	2002	60,866	11
	2003	60,485	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DANVILLE CARE CENTER COUNTY VERMILLION

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-34-100-005-0060	NURSING HOME	$ 24,146.82	$ 24,146.82
2.	18-33-200-016-0060	NURSING HOME	$ 36,338.32	$ 36,338.32
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,485.14	$ 60,485.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1998		$ 2,954,225	$ 152,666		$ 152,666	$	$ 1,068,668	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1989	34,167	1,085	30	1,139	54	16,789	9
10	LEASEHOLD IMPROVEMENTS			1990	17,344	551	30	578	27	8,178	10
11	LEASEHOLD IMPROVEMENTS			1991	45,376	1,441	30	1,513	72	19,957	11
12	LEASEHOLD IMPROVEMENTS			1992	12,043	382	30	401	19	4,908	12
13	LEASEHOLD IMPROVEMENTS			1993	9,213	236	30	307	71	3,221	13
14	LEASEHOLD IMPROVEMENTS			1994	8,304	213	39	213	(0)	2,246	14
15	NURSING STATION			1995	14,331	367	39	367	0	3,411	15
16	DOOR/LIGHT FIXTURES			1995	17,592	451	39	451	0	4,190	16
17	FIRE ALARM & ELECTRICAL WORK			1995	2,420	62	39	62	0	576	17
18	SHOWER/BATH CONST.			1995	4,704	121	39	121	(0)	1,124	18
19	NURSECALL REPAIR			1996	1,655	42	39	42	0	382	19
20	SMOKE DETECTORS/LIGHT FIXTURES/DOOR			1996	5,894	151	39	151	0	1,325	20
21	RESURFACE PARKING AREA			1996	12,910	861	15	861	(0)	7,308	21
22	ROOF REPAIR			1966	12,742	327	39	327	(0)	2,657	22
23	WARDROBE UNITS			1996	8,361	214	39	214	0	1,721	23
24	FLOORING			1996	2,444	63	39	63	(0)	506	24
25	CARPET/WALLPAPER/BUMPER GUARDS/COVE BASE			1997	19,014	488	39	488	(0)	3,698	25
26	PARKING LOT REPAIR			1997	1,500	100	15	100		750	26
27	PAVILION CONST.			1997	8,297	213	39	213	(0)	1,631	27
28	THERAPY ROOM ADDITION			1998	320,230	8,211	39	8,211	0	49,609	28
29	NORTH WING RENOVATION			1998	65,143	1,670	39	1,670	0	10,090	29
30	BUMPER GUARDS			1998	9,285	238	39	238	0	1,657	30
31	CEILING REPAIR/DRYWALL/TILE			1999	17,083	438	39	438	0	2,232	31
32	NURSE CALL/FIRE ALARM SYSTEM			1999	5,616	144	39	144		800	32
33	ROOF REPAIR/AIR EXHAUSTS			1999	7,095	182	39	182	(0)	1,014	33
34	LANDSCAPING			1999	12,535	836	15	836	(0)	4,597	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	2000	$ 3,436	$ 491	7	$ 491	$ (0)	$ 1,741	37
38	CARPET/COVE BASE/WALLPAPER	2000	9,734	1,391	7	1,391	(0)	4,903	38
39	BATHROOM REPAIR/REMODEL	2000	11,104	404	27.5	404	(0)	1,926	39
40	HOT TUB ROOM REPAIR/REMODEL	2000	6,700	244	27.5	244	(0)	1,158	40
41	ALARMA SYSTEM/DOORS/CAMERAS	2000	15,171	552	27.5	552	(0)	2,626	41
42	NORTH WING RENOVATION	2000	4,809	175	27.5	175	(0)	828	42
43	WATER HEATER VALVE	2000	1,026	37	27.5	37	0	180	43
44	SECURITY DOOR	2001	693	25	27.5	25	0	87	44
45	WATER HEATER	2001	684	25	27.5	25	(0)	86	45
46	ROOF REPAIRS	2002	10,000	364	27.5	364	(0)	773	46
47	CONCRETE REPAIRS	2002	1,592	58	27.5	58	(0)	124	47
48	ROOF	2003	23,000	836	27.5	836	0	1,219	48
49	BEDROOM CEILING/WALLS	2003	3,300	120	27.5	120		175	49
50	BLINDS	2003	3,118	997	5	624	(373)	1,248	50
51	VENT TO ROOF	2003	5,700	207	27.5	207	0	302	51
52	INSTALL PULL STATIONS	2003	1,033	38	27.5	38	(0)	55	52
53	ELECTRIC DOOR HOLDER/CLOSER	2003	852	31	27.5	31	(0)	45	53
54	GAS/ELECT ROOF TOP UNIT	2003	6,542	238	27.5	238	(0)	347	54
55	WATER HEATER REPAIR	2003	1,971	72	27.5	72	(0)	105	55
56	REPLACE DOORS/EXIT DEVICES	2003	13,040	474	27.5	474	0	691	56
57	NURSE CALL SYSTEM	2003	9,000	327	27.5	327	0	477	57
58	HEAT/COOL ROOF TOP UNIT	2003	5,287	192	27.5	192	0	280	58
59	DURO LAST ROOFING SYSTEM	2003	41,750	1,518	27.5	1,518	0	2,214	59
60	REPAIR CEILING/DOORS	2003	8,000	291	27.5	291	(0)	424	60
61	NURSE CALL SYSTEM/PULL STATIONS	2004	7,368	134	27.5	134	(0)	134	61
62	CEILING PANEL REPLACEMENT	2004	999	18	27.5	18	0	18	62
63	HANDRAILS	2004	1,406	26	27.5	26	(0)	26	63
64	SKYLITE	2004	2,400	44	27.5	44	(0)	44	64
65	WALL A/C UNITS	2004	10,249	186	27.5	186	0	186	65
66	ALARM SYSTEM	2004	1,995	20	27.5	36	16	36	66
67	WALLPAPER/PAINTING/COVE REPLACEMENT	2004	26,302	417	27.5	478	61	478	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,867,784	$ 181,705		$ 181,650	$ (55)	$ 1,246,179	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 320,050	$ 24,677	$ 47,415	$ 22,738	5-7 YRS	$ 206,655	71
72	Current Year Purchases	32,838	19,703	4,865	(14,838)	5	4,865	72
73	Fully Depreciated Assets	229,001					229,001	73
74			30,111	30,111				74
75	TOTALS	$ 581,889	$ 74,491	$ 82,391	$ 7,900		$ 440,521	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT DEPT	1995 DODGE VAN	1994	$ 19,595	$	$	$		$	76
77	PATIENT TRANSP	1996 FORD WAGON	2000	21,907	2,524	4,381	1,857	5	19,978	77
78										78
79										79
80	TOTALS			$ 41,502	$ 2,524	$ 4,381	$ 1,857		$ 19,978	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,841,175	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 258,720	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 268,422	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,702	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,706,678	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,722 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 5,945	$		$ 5,945	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,270			3,270	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			1,175			1,175	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				91,041		91,041	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					42,452		42,452	13
14	TOTAL			$		$ 10,390	$ 133,493		$ 143,883	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,679)	975,314		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,498		6
7	Other Prepaid Expenses	6,061		7
8	Accounts Receivable (owners or related parties)	(297,082)		8
9	Other(specify): R/E TAX ESCROW	253,488		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 980,279	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	913,559		15
16	Equipment, at Historical Cost	623,391		16
17	Accumulated Depreciation (book methods)	(752,265)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 784,685	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,764,964	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 550,511	$	26
27	Officer's Accounts Payable	657,090		27
28	Accounts Payable-Patient Deposits	24,050		28
29	Short-Term Notes Payable	669,037		29
30	Accrued Salaries Payable	71,443		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,460		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,695		32
33	Accrued Interest Payable	2,191		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,054,477	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,054,477	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (289,513)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,764,964	$	48

*(See instructions.)

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 71,101	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 71,101	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(360,614)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (360,614)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (289,513)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,813,792	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,813,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	158,820	6
7	Oxygen	26,005	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 184,825	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	110	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 110	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,351	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,351	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,001,078	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,079,443	31
32	Health Care	1,987,069	32
33	General Administration	1,348,011	33
	B. Capital Expense		
34	Ownership	693,486	34
	C. Ancillary Expense		
35	Special Cost Centers	143,883	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,361,692	40
41	**Income before Income Taxes (line 30 minus line 40)****	(360,614)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (360,614)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,845	2,080	$ 67,506	$ 32.45	1
2	Assistant Director of Nursing	398	398	7,683	19.30	2
3	Registered Nurses	6,925	6,973	175,942	25.23	3
4	Licensed Practical Nurses	21,759	22,407	422,361	18.85	4
5	Nurse Aides & Orderlies	84,672	86,812	757,456	8.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,790	6,158	155,832	25.31	8
9	Activity Director	490	634	6,047	9.54	9
10	Activity Assistants	8,282	8,658	61,759	7.13	10
11	Social Service Workers	3,148	3,388	68,120	20.11	11
12	Dietician					12
13	Food Service Supervisor	3,192	3,424	42,023	12.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,205	12,902	106,068	8.22	15
16	Dishwashers	8,816	9,037	67,211	7.44	16
17	Maintenance Workers	7,949	8,280	70,608	8.53	17
18	Housekeepers	24,989	25,905	184,848	7.14	18
19	Laundry	11,542	12,180	82,855	6.80	19
20	Administrator	1,923	2,080	59,429	28.57	20
21	Assistant Administrator	1,896	2,080	42,697	20.53	21
22	Other Administrative					22
23	Office Manager	2,492	2,575	38,014	14.76	23
24	Clerical	8,168	9,134	94,947	10.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CARE PLAN COO	288	288	4,962	17.23	32
33	Other(specify) MARKETING	2,000	2,080	30,904	14.86	33
34	TOTAL (lines 1 - 33)	218,769	227,473	$ 2,547,272 *	$ 11.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	225	$ 9,004	1-3	35
36	Medical Director	750/month	7,548	9-3	36
37	Medical Records Consultant	40	1,323	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly	400	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		156	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	80	2,472	11-3	44
45	Social Service Consultant	88	3,466	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	433	$ 24,369		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,087	$ 44,553	10-3	50
51	Licensed Practical Nurses	2,515	80,491	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	3,602	$ 125,044		53

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CLAIRE MATHENY	ADMIN		$ 59,429
AMY WEIR	ASST ADMIN		42,697
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,126

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 61,440
TOTAL (agree to Schedule V, line 17, col. 3)	$ 61,440
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
NONE		
SEE SCHEDULE ATTACHED		114,249
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 114,249

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 113,824
Unemployment Compensation Insurance		95,923
FICA Taxes		189,479
Employee Health Insurance		104,824
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,736
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		2,062
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		30,645
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 538,493

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
NONE		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,462
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	4,119
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	5,165
DUES & SUBSCRIPTIONS	250
MGMT CO ALLOCATION	52
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,119)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,929

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,028
Seminar Expense	
	5,313
MGMT CO ALLOCATION	11,529
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,870

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **NO**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **109,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees